Indiana State Department of Health

Division of Acute Care
APPLICATION FOR LICENSE
APPROVAL TO OPERATE A HOSPICE PROGRAM
(PURSUANT TO IC 16-25-3)
Form approved by State Board of Accounts, 1999
SF 43813 (R2/7-99)

1. All questions on this application must be printed or typed and answered completely with supporting documentation attached. Incomplete or illegible applications will be returned without being processed.
2. License and/or Approval renewal must be obtained annually.
3. This application and the License or Approval which may be issued as a result, are neither assignable nor transferable.
4. Previous receipt of a Certification is not a guarantee that a License or Approval will be issued.
5. A non-refundable application fee in the amount of $100.00 must accompany this application. No License or Approval shall be issued without receipt of this fee.
6. Mail this application, accompanying documentation and non-refundable fee to:

Indiana State Department of Health
Division of Acute Care
Section 4A
2 North Meridian Street
Indianapolis, Indiana 46204

A. APPLICANT/OWNER INFORMATION

1. Name of hospice program _____
   Street Address _____
   City _____ County _____ Zip Code _____
   Telephone _____ Fax number _____
   Employer identification number _____

   Name of owner/operator (if different than above) _____
   Street Address _____
   City _____ County _____ Zip Code _____
   Telephone _____ Fax number _____
   Employer identification number _____

2. Does the applicant intend to operate more than one site?

Yes ☐ No ☐

If yes, on a separate sheet, please provide a list of each additional site, including address, and phone number.

3. Is this hospice owned by a separately licensed entity?

Yes ☐ No ☐

If yes, please check the appropriate box and give the license information in the space provided.

Hospital ☐ Health Facility ☐ Home Health Agency ☐ Other ☐

License number (include a copy with application) _____
Date issued_____ Date expires_____

4. Has applicant been previously licensed or received a certification for operation of a hospice from the Division?

Yes ☐ No ☐

If yes, please provide the license or certificate number (include a copy with application) _____

5. What geographic service area does applicant serve? Please identify by city, county and township. _____
_____
_____

If the geographic service area is different from that previously served by applicant, please state, describing the previous service area and reason for change.
_____
_____
_____

B. STAFF

1. Medical Director
   Name _____
   Indiana License Number _____

   a. Has the medical director ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health care services?

   Yes ☐ No ☐

   If yes, state on a separate sheet the facts of each case and how it was resolved.

   b. Has the medical director's license (if applicable) lapsed, been suspended or revoked?

   Yes ☐ No ☐

   If yes, explain on a separate sheet of paper the place, date and agency initiating action, action taken and reason.

2. Patient/Family Care Coordinator
   Name _____
   Indiana License Number (if applicable) _____

   a. Has the coordinator ever been convicted of any criminal offense relating to, or in any way associated with, the provision of health care services?

   Yes ☐ No ☐

   If yes, state on a separate sheet the facts of each case and how it was resolved.

   b. Has the coordinator's license (if applicable) lapsed, been suspended or revoked?

   Yes ☐ No ☐

   If yes, explain on a separate sheet of paper the place, date and agency initiating action, action taken and reason.

   c. On a separate sheet, please list the coordinator's complete educational background and employment history. Include post-secondary education and health related experience.

3. Governing Body

   Please list the names and addresses of the Governing Body Officers (use additional sheets if necessary).

Name	**Business Address**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Does the applicant employ, contract or use home health aides in providing services to its patients?

   Yes ☐ No ☐

   If yes, please provide a list of all home health aides presently employed, contracted or used by applicant, along with a copy of the criminal background check and documentation of applicant's check of the State Nurse Aide Registry for each such aide.

5. Does the applicant use volunteers in providing services to its patients?

   Yes ☐ No ☐

   If yes, please provide a list of all volunteers used by applicant, along with a copy of the documentation of the criminal background check and documentation of applicant's check of the State Nurse Aide Registry for each such volunteer who acts as a home health aide.

C. REPRESENTATIONS

The undersigned hereby makes application for a license to operate a hospice in the State of Indiana, and in support of this application, represents and shows that the applicant is able to comply with the hospice licensure/approval statute, IC 16-25-3 and accompanying regulations.

I swear or affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all rules and regulations governing the licensure/approval of Hospice programs in Indiana.

If signed by any individual other than the Chairman or President of the organization, an affidavit must be submitted with the application, affirming that said person has been given the power to bind the applicant.

_____	_____
Name of Authorized Representative (Typed)	Title
_____	_____
Signature of Authorized Representative	Date

Attachment A

CHECKLIST OF DOCUMENTS THAT MUST BE SUBMITTED
WITH APPLICATION

1. Non-refundable application fee of $100.00.

2. Disclosure document (see Attachment B).

3. A copy of the Medical Director's license and resume.

4. A copy of the Patient/Family Care Coordinator's license and resume.

5. If the applicant (or its owner/operator) is an Indiana corporation, a copy of the "Certificate of Incorporation" signed by the Indiana Secretary of State.

6. If the applicant (or its owner/operator) is an out-of-state corporation, a copy of the "Certificate of Authority" signed by the Indiana Secretary of State.

7. A list of each and every home health aide employed, contracted or utilized (this includes volunteers) by the applicant at the time of the application, including date of hire.

8. Completed criminal history reports on each and every home health aide listed by the applicant.

9. A list of each and every volunteer utilized by the applicant at the time of the application, including date of hire.

10. Documentation by the applicant of its inquiry with the State Nurse Aide Registry regarding each home health aide listed by the applicant. Documentation is not required to take any specific form, however, must include the following information:

    a. Name and title of individual conducting the Home Health Aide check;
    b. Date of check;
    c. Name and social security number of the home health aide;
    d. Results of check ("Finding", "No Finding", "Not listed"); and
    e. If a finding exists, the nature of that finding, and whether it is being contested.

Attachment B

DISCLOSURE STATEMENT

In order for the Department to grant an application for licensure or approval of a hospice program, the applicant must be able to demonstrate its ability to comply with the minimum standards established by IC 16-25-3, effective July 1, 1999. This ability to comply is demonstrated by the applicant through what is known as a "Disclosure Statement", which is submitted each year along with the initial or renewal application.

There is no required format for a Disclosure Statement, however there are two (2) topics that must be addressed; services and supplies and patient rights. In addition, a toll free number must be provided should an individual have any questions or comments about a program.

Listed below are those minimum standards that must be included in the applicant's Disclosure Statement. Further information may be included if the applicant wishes.

A. A description of all hospice services. This includes the following:

1. Core Services:
   i. Physician services;
   ii. Nursing services;
   iii. Medical social services; and
   iv. Counseling services.

2. Other services, including but not limited to:
   i. Physical therapy;
   ii. Occupational therapy;
   iii. Speech-language pathology;
   iv. Home health aide;
   v. Homemaker;
   vi. Medical supplies; and
   vii. Short term inpatient care.

B. A description of supplies provided to clients, including how those supplies are made available or delivered.

C. A statement of patient rights, including:

1. Acknowledgement that hospice services and supplies shall be dispensed on a patient's individual needs.

2. Description of an internal dispute resolution process, including:

i. How the dispute resolution process is initiated;
ii. The name of the ultimate decision-maker; and
iii. How a patient may appeal a decision rendered under this procedure.

3. A statement that patient has the right to participate in the planning of his care.

4. A statement that the patient has the right to refuse any component of the hospice's services or supplies.

5. The Indiana State Department of Health's toll-free number: 1-800-227-6334.